

**Everett/Snohomish County Continuum of Care
Verification of Disability**

Where disability is an eligibility requirement for entry into the Project (e.g., Permanent Supportive Housing under the Continuum of Care (CoC) Program), intake staff are required to document disability per the Defining "Homeless" Rule, FR-5333-F-02. This form should be attached to the Verification of Homelessness form.

PLEASE NOTE: This form should be used *only* where disability is an eligibility requirement. Projects that are not funded to serve persons with disabilities should not make inquiries as to whether an applicant has a disability. For projects serving Chronically Homeless persons, do not use this form for the purposes of certifying chronic homelessness; instead, use the Verification of Chronic Homelessness form.

Applicant Name _____

Instructions: Check the box to indicate the documentation attached. Third-party documentation **MUST** be used; self-certifications of disability are insufficient to document disability.

Disability Definition	Documentation Attached
<p>Physical, mental, or emotional impairment:</p> <p>A person shall be considered to have a disability if he or she has a condition that:</p> <ul style="list-style-type: none"> - Is expected to be long-continuing or of indefinite duration; - Substantially impedes the individual's ability to live independently; - Could be improved by the provision of more suitable housing conditions; and - Is a physical, mental, or emotional impairment, including impairment caused by alcohol or drug abuse, posttraumatic stress disorder, or brain injury <p>OR</p> <p>Development disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)</p> <p>OR</p> <p>HIV/AIDS:</p> <p>A person will be considered to have a disability if (s)he has acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV)</p>	<p><input type="checkbox"/> Written verification of the disability from a professional who is licensed* by the state to diagnose and treat the disability and his/her certification that the disability:</p> <ul style="list-style-type: none"> - Is expected to be long-continuing or of indefinite duration - Substantially impedes the individual's ability to live independently <p>OR</p> <p><input type="checkbox"/> Written verification from the Social Security Administration</p> <p>OR</p> <p><input type="checkbox"/> Receipt of a disability check (e.g., Social Security Disability Insurance check or Veteran Disability Compensation)</p>

* An exception to the licensing requirement is made only for persons certified as a Chemical Dependency Professional, as defined in Chapter 18.205 RCW.

Name/Title of Person Completing Form _____

Signature _____ Date _____